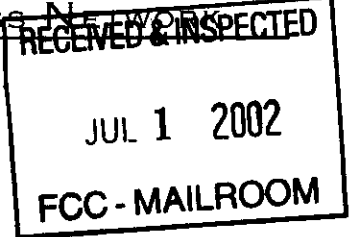


ALASKA FEDERAL HEALTH CARE ACCESS NETWORK



June 27, 2002

Commission's Secretary
Office of the Secretary
Federal Communications Commission

To whom it may concern:

Please see the attached comments in response to the FCC's Notice of Proposed Rulemaking (WC Docket No 02-60) regarding Universal Service Support for Rural Health Care programs. These comments are being supplied by staff members of the Alaska Federal Health Care Access Network (AFHCAN).

The Alaska Federal Health Care Access Network (AFHCAN) is a federally funded telehealth program that aims to improve access to health care for federal beneficiaries at 235 sites throughout the State of Alaska. Being one of the world's largest telehealth projects, the AFCHAN staff has developed extensive experience working with rural organizations that rely on the Universal Service program for connectivity.

The RHCD/USAC program has been instrumental in improving health care for Alaskans. We applaud the FCC for recognizing the need for changes to this program in order for the mechanism to reach its full potential. We support the program's continuation and growth and urge the FCC to consider the suggestions outlined in the attached paper.

Regards

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This paper contains comments on the FCC's Notice of Proposed Rulemaking (WC Docket No 02-60) regarding Universal Service Support for Rural Health Care programs. These comments are being supplied by staff members of the Alaska Federal Health Care Access Network (AFHCAN).

Summary of Recommendations

- 1. Because of the inherent differences between satellite and wireline connectivity, we recommend applicants that rely on satellite connectivity as the only available means of transport be allowed to use factors in addition to cost (such as quality of service, committed information rate, uptime) when selecting a vendor.**
- 2. Discounts should be provided to health care providers for Internet access as long as the cost to provide such services in rural areas exceeds the cost to provide similar services in urban areas of the state. Support for Internet access in rural areas should use an urban-rural rate comparison similar to the existing rate comparisons for eligible services.**
- 3. The Maximum Allowable Distance (MAD) calculation should be eliminated. It does not apply in most cases in Alaska, and when it does, it prevents us from increasing access to care for Alaskans.**
- 4. The application process should be simplified by:**
 - a) combining the 466, 467, and 468 forms into one easy-to-use form that would save time, labor and confusion for everyone involved.**
 - b) developing a "short-form" for health care providers who have signed multi-year contracts to fill out each year, stating that no change in service has occurred and that service is still in place.**

Background

The Alaska Federal Health Care Access Network (AFHCAN) is a federally funded telehealth program that aims to improve access to health care for federal beneficiaries at 235 sites throughout the state of Alaska. The majority of the sites are not accessible by road, and do not have terrestrial telecommunications infrastructure. The RHCD/USAC program has been instrumental in improving health care for Alaskans.

AFHCAN has constructed a wide area network to bring telehealth services such as “store and forward telemedicine”, teleradiology, and video conferencing to 235 remote Alaskan communities. Many of the links rely on satellite and microwave technologies which would not be financially feasible if not for the Universal Service support programs.

During the history of these programs, the staffs of the Rural Health Care Division (RHCD) of the Universal Services Administrative Corporation (USAC) and the FCC have been very helpful and receptive to the special needs of Alaskan health care providers. Providing high-quality, state-of-the-art health care in rural Alaska presents many challenges, particularly with regard to telecommunications.

These comments have been prepared by Tom Bunger, a Network Engineer with AFHCAN project who has worked closely with Alaska’s rural health care providers for the past year and has lived in and worked in rural Alaska in the telecommunications industry for the past nine years. These comments also reflect the views of the AFHCAN project administration that has reviewed and contributed to this document.

We applaud the FCC for recognizing the need for changes to this program in order for the mechanism to reach its full potential. We support the program's continuation and growth and respectfully present the following comments and recommendations for FCC review:

Recommendations

- 1. Because of the inherent differences between satellite and wireline connectivity, we recommend applicants that rely on satellite connectivity as the only available means of transport be allowed to use factors in addition to cost (such as quality of service, committed information rate, uptime) when selecting a vendor.**

As noted by the Commission in paragraph 34 of the NPRM, it is difficult to compare services offered in rural and urban areas because "some less expensive urban services are unavailable at any price in rural areas and health care providers are thus required to seek out more expensive services." This is especially true in Alaska where there are many communities that are not connected to the road system – in fact 75% of Alaskan communities and 25% of Alaska residents are unconnected by road to a hospital. These sites are also disconnected from a terrestrial telecommunication backbone, and therefore rely on satellite technology to receive all telecommunications services.

Satellite connectivity is inherently more prone to loss of connectivity, poor throughput, interrupted service, and loss of signal for prolonged periods of time. The deciding factor regarding comparison of services should be related to a guaranteed level of service from the carrier with respect to speed, available

bandwidth, uptime, and overall quality such that the service is capable of delivery high-quality healthcare in any area.

Currently, potential funding recipients are asked by USAC to make decisions on bids from telecommunications carriers based primarily on cost. In working with Alaskan communities served only by satellite, we have experienced broad differences between satellite and wire-based technologies in regard to bandwidth, latency, performance of real-time applications, and uptime. When comparing satellite services to wire-based services, cost should be just one factor in a larger matrix of factors used to decide on the best carrier.

Local organizations are best equipped to recognize and differentiate between these factors when comparing quotes from various vendors. An approved “comparison matrix” with a significant (but not total) weighting to cost would allow these factors to be included in the decision making process. This would not only empower the local organization in the process, but assure the better spending of federal funds.

- 2. Discounts should be provided to health care providers for Internet access as long as the cost to provide such services in rural areas exceeds the cost to provide similar services in urban areas of the state. Support for Internet access in rural areas should use an urban-rural rate comparison similar to the existing rate comparisons for eligible services.**

Broadband Internet access is simply not available in many communities, or available at prohibitive costs due to the transport mechanism required to deliver

access over satellite connectivity. More than half of Alaskan communities do not have local access to the Internet (Denali Commission survey, January, 2001).

Yet affordable access to the Internet is vital to the delivery of healthcare in remote areas. The Internet contains valuable health information, and serves as a way for health professionals to keep up with continuing education, and keep in contact with each other. The Internet can also be used as a transport mechanism for healthcare networks using Virtual Private Network (VPN) technologies. We are exploring the use of broadband Internet services as a cost-effective way to provide telehealth services such as video, distance learning, and teleradiology.

We recommend subsidizing Internet access at rural sites to reduce the cost to comparable service at the nearest “urban” site. For instance, if the cost of DSL service providing an upstream bandwidth of 128k and a downstream bandwidth of 768k costs \$100 per month in Nome, Alaska, but only costs \$50 per month in Anchorage, Alaska, then the per month USAC subsidy for the Nome line should be \$50 per month.

3. The Maximum Allowable Distance (MAD) calculation should be eliminated. It does not apply in most cases in Alaska, and when it does, it prevents us from increasing access to care for Alaskans.

The application of a “Maximum Allowable Distance” (MAD) rarely applies to in-state circuits, as most of the subsidized circuits in Alaska are satellite based and Alaska has only a single “urban” area. However, connectivity between Alaska and other states, notably Hawaii, is available through terrestrial infrastructure

where the MAD calculation applies – and this limits the ability to have such connectivity subsidized.

This is critical because Alaska suffers a significant shortage of “in-state” specialists, and relies on connectivity to other states to gain access to specific specialties. For example, a critical shortage of Alaskan radiologists is creating a need for dedicated broadband connectivity from Alaskan tertiary care facilities to sites with excess radiological capacity, notably in Hawaii. While Alaska is the third least populous state, and has the lowest population density, Alaska ranks 48th among the states in the ratio of doctors to residents (in 1998). Only Idaho and Oklahoma had fewer doctors per 100,000 people (State of Alaska Rural Health Plan, 2000).

Because Alaska does not have specialists in some areas of medicine, the closest care available to some Alaskans is out of state, and the MAD acts as a barrier to them receiving this care. Telemedicine by its very definition is supposed to remove distance as a limitation to accessing health care. The MAD prevents this.

4. The application process should be simplified by:

- a) combining the 466, 467, and 468 forms into one easy-to-use form that would save time, labor and confusion for everyone involved.**
- b) developing a “short-form” for health care providers who have signed multi-year contracts to fill out each year, stating that no change in service has occurred and that service is still in place.**

The unnecessary complexity of the process and the lack of staff resources have deterred many organizations -- often the smallest and most needy organizations -- from even starting the funding paperwork.

The initial form 465 should continue to be the application form. USAC can then provide a letter to proceed when application is approved. The rural healthcare applicant would then solicit bids and select a carrier/vendor following procurement policies. The final form could be jointly submitted by the healthcare applicant and the selected telecommunications carrier. Once installation is completed, the initial bill and copy of contract could be submitted to USAC as proof for payment. The applicant remains responsible for following procurement policies and retaining documentation of RFP and selection process.

On subsequent years, we believe there are significant advantages to reducing the paperwork through a single "short form" (465 EZ). We recommend that where competitive bidding is done and long-term contracts are signed, that USAC agree to create an "EZ" type form for the applicant and telecommunication provider to sign and stipulate that the service is still in place and that the rates have not changed.
